Ball State University  
Amelia T. Wood Health Center  
Pre-Travel Assessment Form  

Please complete this form prior to the appointment for your travel abroad physical

Name:_________________________________________ Date of Birth:__________________________

Dates of Trip: Departure Date:________________ Return Date:________________ Overall Length of Trip________________

Trip Itinerary:

<table>
<thead>
<tr>
<th>City</th>
<th>Provence/Region</th>
<th>Country</th>
<th>Length of stay in area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type of Trip:

1. Will you be traveling alone, with family/friends or in a group?_____________________________________________________

2. What activities do you plan to do while traveling? (examples: working in medical/dental field, working with animals/birds, outdoor activities such as hiking/camping, snorkeling/scuba diving) ____________________________________________________________

3. Will you be staying in areas that are urban, rural, high altitude or other?_______________________________________________

4. What type of accommodations will you have? (modern hotel, with local family, hostel, tent/cabin?)_______________________

Medical History

Please list any ongoing or past medical problems:
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

1. Do you have any conditions treated with immunosuppressive drugs such as: cancer, organ transplant, rheumatoid arthritis, ulcerative colitis, crohn’s disease, lupus, HIV, etc. ________________________________________________________________

2. Do you have a history of mental illness including depression or anxiety?________________________________________________

3. Have you recently been treated with steroids?___________________________________________________________

4. Women only: are you pregnant, planning pregnancy or breastfeeding?______________________________________________

5. Do you have any allergies, for example to eggs, medications or nuts?______________________________________________

6. Have you ever had a serious reaction to a vaccine in the past?__________________________________________________

7/28/2014 rev. 4/7/2017
7. Have you ever used malaria medication in the past? If so, what and when?

Please list all prescription, over-the-counter, birth control, vitamins and supplements that you are taking and dosages.

Travel Immunization history

- Typhoid-oral or injection, date__________________________  Yellow fever, date__________________________
- Hepatitis A, dates____________________________________  Hepatitis B, dates__________________________
- Adult polio booster, date______________________________  Meningococcal, date_________________________
- Japanese Encephalitis, dates____________________________  Rabies, dates______________________________